Provider Quick Reference for Commonwealth Coordinated Care Plus (CCC Plus)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

For more details about this program –
Visit the website at:
http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

Or e-mail at: CCCPlus@dmas.virginia.gov
CMHRS Specific Inquiries: CCCPlusCMHRS@dmas.virginia.gov

Important: Information contained in this guide is subject to change without notice

November 2017

COMMONWEALTH COORDINATED CARE PLUS
PROVIDER QUICK REFERENCE GUIDE

Table of Contents

Glossary of Terms

Carved-Out Services: Specific services are paid through Medicaid fee-for-service for CCC Plus program enrolled individuals; these specific services for managed care enrolled individuals are being "carved-out" from the other services offered by a MCO and will remain fee-for-service.

Clean Claim: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim without errors originating in the Contractor's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Coinsurance – The portion of a Medicaid member's Medicare, Medicaid, or other insurance, allowed charges for which the member is responsible.

Co-payment: Some Medicaid members must pay a small amount for certain services. Most of the co-payments (also referred to as copays) are $1.00 to $3.00; inpatient hospital is $100.00 per admission. CCC Plus members are not charged co-payments for services rendered, other than the member's patient pay towards long term services and supports (if they have one). See Patient Pay.

Dual Eligible: Individuals who are enrolled in Medicare (Part A or, B) and full Medicaid.

Excluded Populations: Individuals in these populations are not CCC Plus program eligible. The coverage for these individuals will continue through fee-for-service or through another DMAS managed care program.

Long Term Services and Supports (LTSS): Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care. LTSS are provided over a long period of time, usually in homes and communities, but also in nursing facilities.

Managed Care Organization (MCO): MCOs are health care plans contracted with DMAS to provide services and coordinate health care services through a network of providers for their members.

National Committee for Quality Assurance (NCQA): The National Committee for Quality Assurance (NCQA) is an independent accreditation organization that evaluates the quality and service provided by health plans, including managed care organizations (MCOs), accountable care organizations (ACOs), managed behavioral health organizations (MBHOs), etc.

Patient Pay: Members with a certain amount of income may have to contribute toward the cost of their long term services and supports. *Patient Pay* is determined by the local Department of Social Services.

Person Centered: Person centered healthcare establishes a partnership among practitioners, members, and their families (when appropriate) to ensure that decisions respect a person's wants, needs, and preferences. Person centered healthcare services encompass qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual.

Commonwealth Coordinated Care Plus Overview

What is CCC Plus?

Commonwealth Coordinated Care Plus (CCC Plus) is a new statewide Medicaid managed care program that will serve approximately 216,000 individuals with complex health care needs, through a person-centered integrated delivery model including medical, behavioral health and long term services and supports. CCC Plus will be implemented in phases between August 1 2017 through January 1, 2018. The implementation plan and timeline is available on the CCC Plus webpage.

This person-centered program includes care coordination and focuses on improving quality, access and efficiency. The General Assembly directed DMAS to transition individuals from the Fee-For-Service delivery model into the Managed Care Model to achieve high quality care and budget predictability.

CCC Plus Eligible Individuals

- Individuals aged 65 and older
- Adults and children with disabilities
- Individuals living in Nursing Facilities (NFs)
- Individuals enrolled in the Commonwealth Coordinated Care Plus Waiver (formerly the Technology Assisted Waiver and Elderly or Disabled with Consumer Direction Waiver)
- Individuals enrolled in one of the three waivers currently serving those with Developmental Disabilities (DD). CCC Plus will cover the individual's non-waiver services only, including primary, acute, pharmacy, behavioral health, and non-LTSS transportation services.
- In January 2018, individuals enrolled in CCC and Medallion 3 Aged, Blind and Disabled (ABD) will transition to CCC Plus.

CCC Plus Excluded Individuals

Some individuals are excluded from CCC Plus. The coverage for these individuals will continue through fee-for-service or through another DMAS managed care program. Excluded individuals include those who meet at least one of the exclusion criteria listed below:

- Individuals enrolled in another Medicaid managed care program (e.g., Medallion and FAMIS managed care, or Program of All-Inclusive Care for the Elderly - PACE). Aged, blind and disabled individuals in Medallion 3.0 will transition to the CCC Plus program.
- Individuals enrolled in the Alzheimer's Assisted Living Waiver or the Department's Money Follows the Person (MFP) Demonstration project.
- Individuals who are in limited coverage groups (e.g., Governor's Access Plan, Family Planning, , or Qualified Medicaid Beneficiary only).
- Individuals who participate in the Health Insurance Premium Payment Program.
- Individuals enrolled in a hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in the CCC Plus program, the individual will remain enrolled in CCC Plus.

- Individuals who are institutionalized in state and in private Intermediate Care Facility/Intellectual Disability and state Intermediate Care Facility /Mental Health facilities. Individuals who reside at Piedmont, Catawba, and Hancock state facilities operated by DBHDS.
- Individuals who reside in nursing facilities operated by the Veterans Administration.
- Individuals who reside in the Virginia Home Nursing Home.
- Individuals who reside in local government owned Nursing Facilities: Bedford County Nursing Home, Birmingham Green, Dogwood Village of Orange County Health and Rehabilitation, Lake Taylor Transitional Care Hospital, Lucy Corr Nursing Home.

CCC Plus Carved-out Services

Some services are paid through Medicaid fee-for-service for CCC Plus program enrolled individuals. These specific services are "carved-out" of the CCC Plus managed care contract and include the following:

- **Dental services (Smiles for Children)**
- **School Health Services** – includes nursing and personal care services, physical and occupational therapies, and speech-language pathology offered to enrolled Medicaid children receiving special education/IEP services in the school setting.
- **Developmental Disability (DD) Waiver Services –** Carve out includes DD Waiver services and related transportation, case management, support coordination services, including when the DD waiver services are covered through EPSDT.
- **Preadmission Screening (PAS)** – Screenings conducted by hospital screeners or community based screening teams using the UAI (Uniform Assessment Instrument) to assess and determine the level of care the individual requires (such as nursing facility, home and community based waivers, PACE, or assisted living facility).
- **Community Mental Health Rehabilitation Services (CMHRS)** – Will continue to be covered for CCC Plus members under the Department's Behavioral Health Services Administrator (BHSA) until December 31, 2017. Beginning January 1, 2018, the CHMRS services will transition to the CCC Plus Member's MCO.

Participating MCO Health Plans

DMAS has contracted with six (6) Managed Care Organizations (MCOs) health plans that will cover all regions of the state. MCOs must be accredited through the National Committee for Quality Assurance (NCQA). Providers must meet MCO credentialing standards (consistent with NCQA guidelines) and state and federal Medicaid requirements. The CCC Plus MCO Contract is posted on the CCC Plus webpage.

The six contracted MCOs are:

Aetna Better Health	https://www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	https://mss.anthem.com/va/Pages/aboutus.aspx
Magellan Complete Care of VA	http://www.mccofva.com/
Optima Health Community Care	https://www.optimahealth.com/communitycare/Pages/default.aspx
United Healthcare Community Plan	http://www.uhccommunityplan.com/
Virginia Premier Health Plan	https://www.vapremier.com/

Provider Information for MCO Enrollment

MCOs are actively building their provider networks. In most cases, providers must contract with an MCO in order to continue serving the CCC Plus population. Providers may contact an MCO Provider Relations department to initiate a conversation about joining an MCO's network. See the Contracting and Credentialing Contact Information for the participating health plans. For Community Mental Health Rehabilitation Services, please use the Contracting Contact information in the CMHRS Transition One Pager.

Before a provider establishes a contract with an MCO, the MCO will work with the provider to make sure the provider is properly credentialed. Credentialing can take from 90-120 days to complete.

See Credentialing 101 for more detail.

Continuity of Care

For the regional implementation of CCC Plus, the continuity of care period is up to 90 days. MCOs have to pay a member's existing Medicaid providers for up to 90 days or the length of the existing service authorization, whichever is sooner. Members in a Nursing Facility (NF) at the time of enrollment will not be required to move even if the NF does not participate. The MCO will pay the NF as an out of network provider. However, the Nursing Facility will need to join a network in order to receive new individuals in the CCC Plus program.

In most cases, individuals will be required to use in network providers. MCOs must go out of network to provide a service that they are unable to provide in network.

Person Centered Care

CCC Plus includes a strong, person-centered delivery model that includes:

- Service coordination/care management component
- Integration with an array of providers for continuity of care
- Ongoing stakeholder participation
- Outreach and education
- The ability for innovation to meet the needs of the dual (Medicare and Medicaid) population

- This person-centered approach is facilitated through a Health Risk Assessment (HRA) and Care Coordination services, both of which are provided by the member's selected health plan.
- The HRA is provided to every member and incorporates medical, behavioral health, long term supports, and social needs.
- Members will be active participants in the HRA process.
- Results of the HRA will be used to confirm the appropriate level of care for the member and plan of care needs.

Care coordination, the hallmark of CCC Plus, is a person-centered process where every member will work with a care coordinator through their health plan who assists the member in gaining access to needed services. The care coordinator will work with the member, their family members, if appropriate, their providers and anyone else involved in their care to help them get the services and supports that they need.

Service Authorization

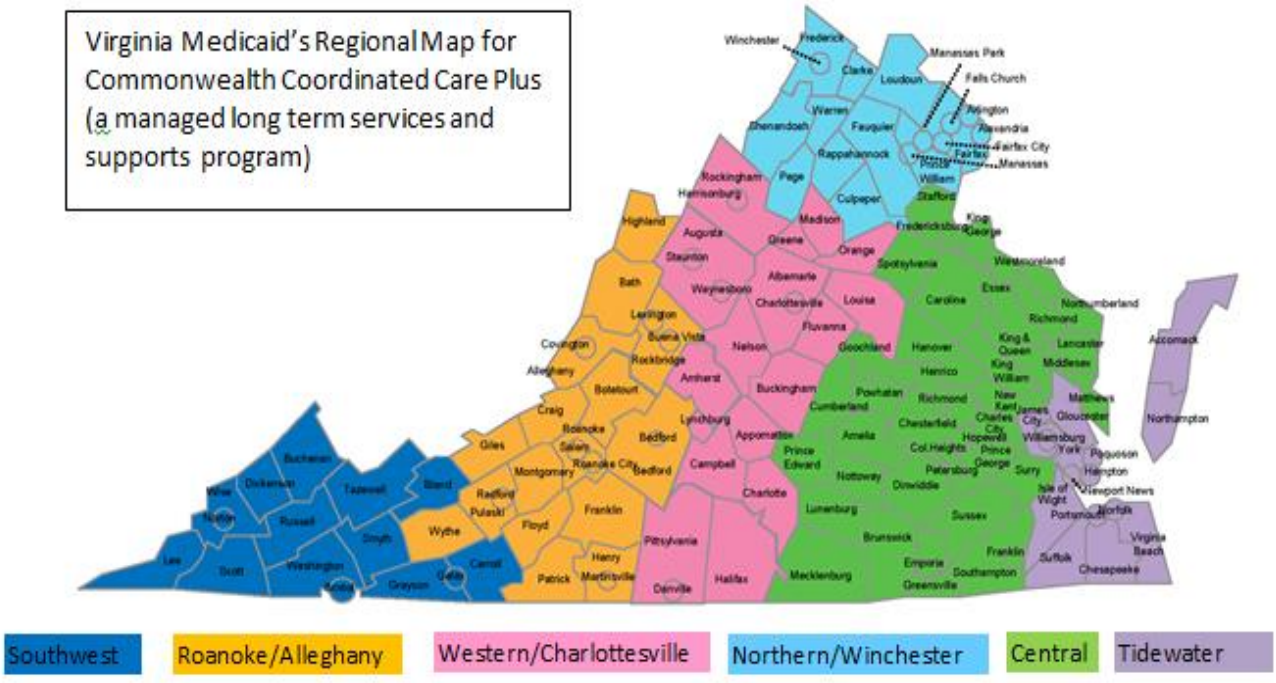
During the continuity of care period, existing service authorizations will continue to be honored by the MCO through the end of the Service Authorization (SA) or 90 days, whichever comes first. MCOs must cover services within at least equal amount, duration, and scope as available through the Medicaid fee-for-service program. MCOs do not have to adhere to the DMAS established criteria. MCOs can choose to require an authorization for services even if DMAS does not require it.

Information for LTSS providers, by provider type(i.e., Nursing Facility, Personal Care, etc) detailing how to submit service authorizations are found here: http://www.dmas.virginia.gov/Content_pgs/mltss-psinfo.aspx

Billing

MCOs will pay providers at least the Medicaid rate for Nursing Facilities, waivers, behavioral health and early intervention services. All MCOs have multiple methods of claim submission. "Clean claims" for LTSS Medicaid-covered services will be paid within 14 days. Billing methods are detailed in the charts described above. Please see the MCO Directory by Region for contact information for the health plans under the information section of the CCC Plus Provider/Stakeholder page.

Commonwealth Coordinated Care Plus Regions and Timeline



CCC Plus will operate statewide, across 6 regions. A list of CCC Plus regions by locality is available at: http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Anticipated Launch Date	Region of Virginia
August 1, 2017	Tidewater
September 1, 2017	Central
October 1, 2017	Charlottesville/Western
November 1, 2017	Roanoke/Alleghany
November 1, 2017	Southwest
December 1, 2017	Northern/Winchester
January 2018	CCC Demonstration (Transition plan determined with CMS)
January 2018	Aged, Blind and Disabled (ABD) (Transitioning from Medallion 3.0)

Member Enrollment for a CCC Plus Medicaid Health Plan

Initial Assignment

Enrollment in the CCC Plus program is required for eligible individuals. Each member will receive an initial assignment into a Health Plan. Some members are already receiving services from a Nursing Facility, Adult Day Health Center, or private duty nurse provider. In these cases, the member is matched with a health plan that includes these existing services in their network. In some cases, the initial assignment will be based on existing membership in a Medicare or Medicaid Health Plan. In other situations, a member's initial assignment may follow a random assignment process between the participating health plans.

Choosing a Health Plan

Each member has a choice between six CCC Plus Medicaid Health Plans. Members receive an initial notification letter that includes a brochure, an initial assignment and a comparison chart of all the health plans. The notification letter includes a call by date on or before the 18th of the identified month in their letter to make their health plan selection.

During the first ninety (90) calendar days of the member's CCC Plus program enrollment, the member can change Health Plans for any reason. To change their health plan, they must call Maximus/CCC Plus Helpline at 1-844-374-9159 or use the website at: https://cccplusva.com/. The member can also change their health plan once a year during open enrollment. They will receive a letter during open enrollment with more information.

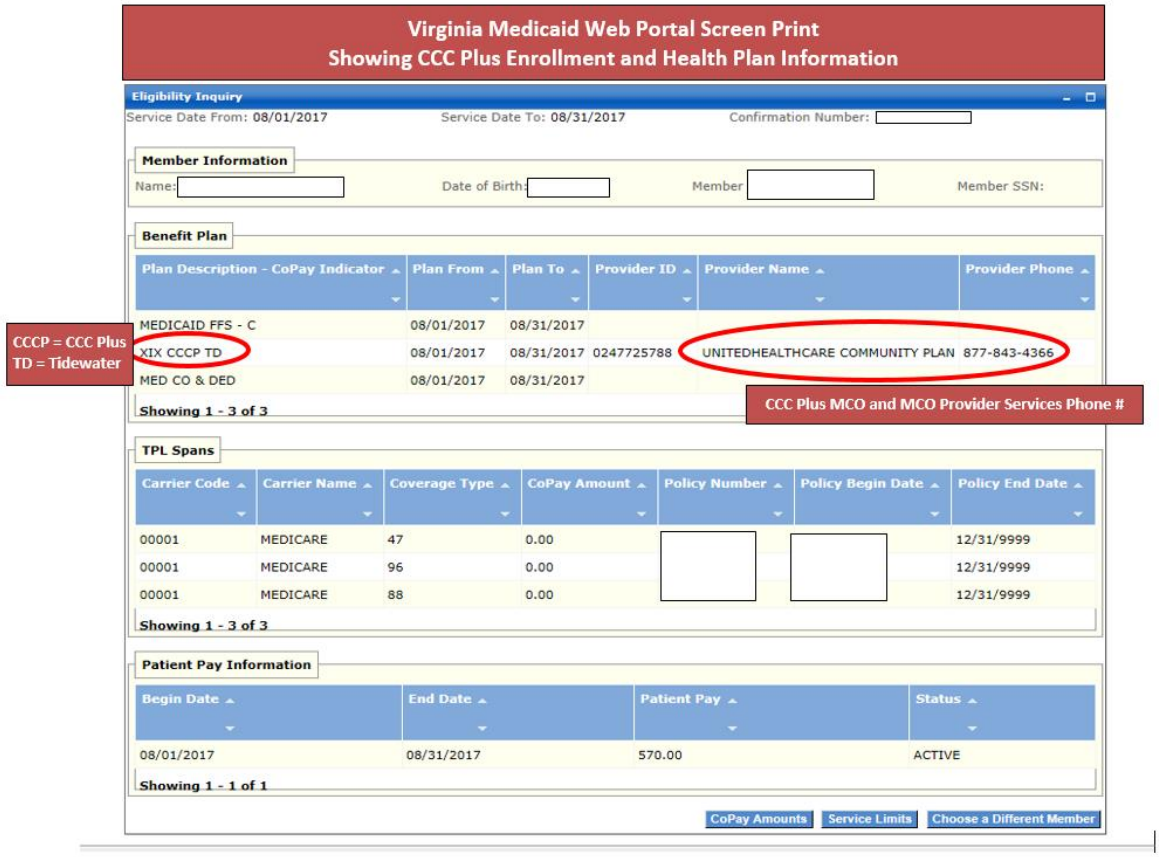
How Members Can Verify Enrollment

A trained MAXIMUS representative can look up the caller's doctors or other healthcare providers to ensure they are in the MCO network. They are also able to review each plan available in the caller's area. This information is also available on the https://cccplusva.com/.

How Providers Can Verify Member Enrollment

It is important for providers to verify a member's Medicaid eligibility at each point of service. Verification of a member's participation in CCC Plus can be done through the DMAS MediCall audio response system (1-800-884-9730 or 1-800-772-9996) or the DMAS web-based internet option, available on the Virginia Medicaid Web Portal, at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. . As members are assigned to a CCC Plus health plan, the status of the enrollment is reflected in the member eligibility information data available on the 21st of every month for the first of the following month. For example, Medicaid enrolled providers can see assignment information beginning on July 21 for individuals who have an August 1st start date in the Tidewater Region.

Both options are available at no cost to the provider. The web-based, automated response system (ARS) limits the provider's verification submission to 10 members at a time. CCC Plus enrollment can also be verified through the member's health plan.



CCC Plus Costs

There are very few member co-pay responsibilities in the CCC Plus program:

- NO premiums
- NO co-payments for doctor or specialist visits
- SOME co-payments for prescriptions for Part D drugs
- NO co-payments or premiums for extra benefits
- CONTINUE to pay long-term services and supports patient pay amounts (as determined by the Member's Medicaid eligibility worker through the local department of social services.)

Outreach and Provider Education

DMAS has offered a variety of outreach and educational opportunities to interested stakeholders, providers and provider associations since CCC Plus development was initiated. Provider town hall

meetings and member town hall meetings are being held in all regions of the state. DMAS is also hosting weekly Member Conference Calls and Provider Calls. The member conference calls, town halls and provider calls will feature CCC Plus updates and opportunities for members, providers/stakeholders to ask questions of DMAS and MCO staff. The schedule for the member conference calls and town halls is available on the CCC Plus website. The provider calls and town hall schedule for providers/stakeholders is available on the CCC Plus website.

DMAS and the health plans will host a Quarterly Advisory Committee. At these meetings DMAS along with the health plans will present on the progress of the program and any upcoming CCC Plus events and projects to the Advisory Committee. The members of the Advisory Committee are made up from a number of consumer advocacy groups, provider associations as well as consumers. Presentations from CCC Plus Advisory Committee meetings are available on the CCC Plus website.

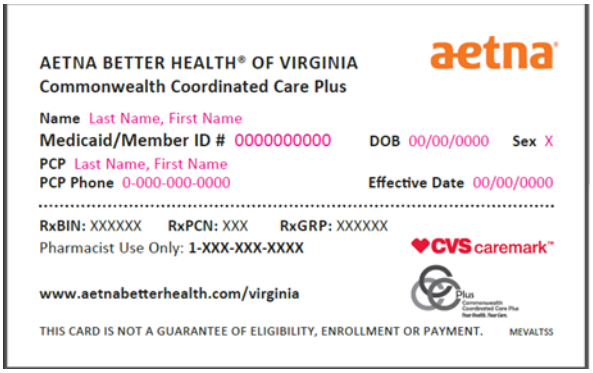
Health Plans Specific Provider Education and Outreach Efforts

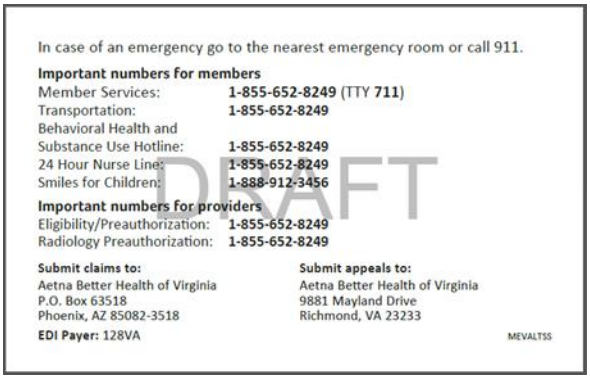
Each of the health plans will host web based training modules for providers. These trainings cover a variety of topics including service authorizations, claims, and care coordination. Website links to the CCC Plus specific web pages for each of the MCO health plans are as follows:

Aetna Better Health	https://www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	https://mss.anthem.com/va/Pages/aboutus.aspx
Magellan Complete Care of VA	http://www.mccofva.com/
Optima Health Community Care	https://www.optimahealth.com/communitycare/Pages/default.aspx
United Healthcare Community Plan	http://www.uhccommunityplan.com/
Virginia Premier Health Plan	https://www.vapremier.com/

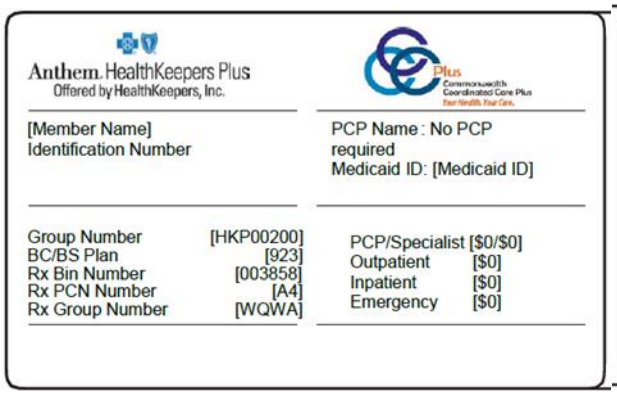
Sample of Member cards for each Health Plan

Aetna Better Health of Virginia:

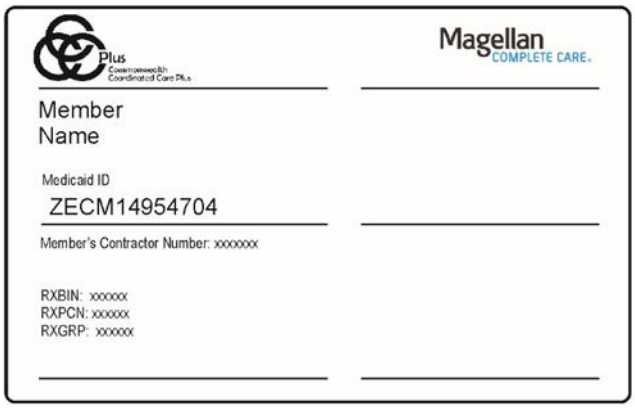


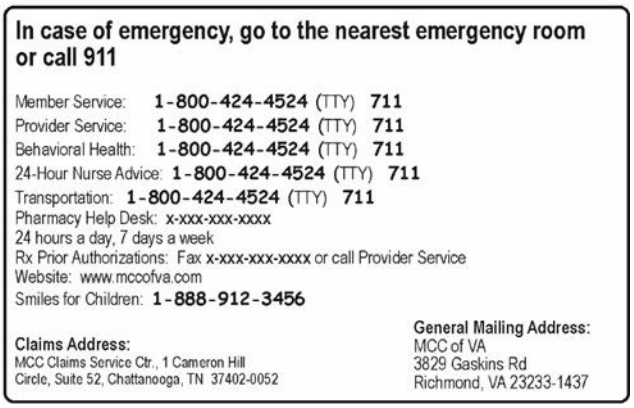


Anthem HealthKeepers Plus:

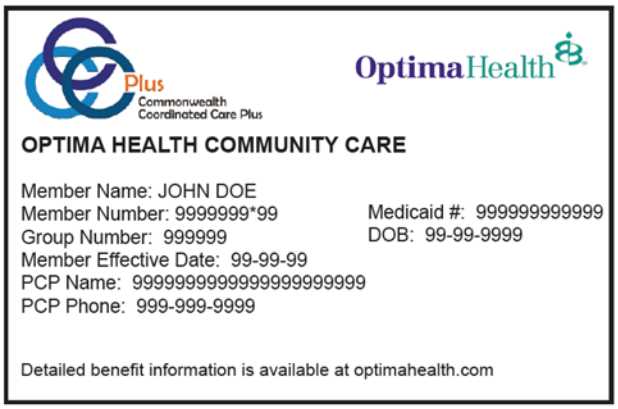


Magellan Complete Care of Virginia:





Optima Health Community Care:



Plus Commonwealth Coordinated Care Plus

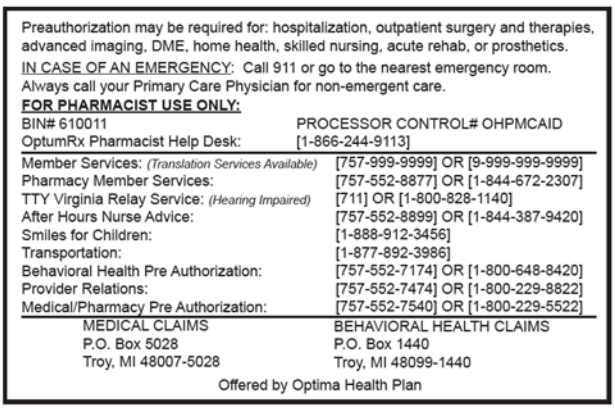
OptimaHealth

OPTIMA HEALTH COMMUNITY CARE

Member Name: JOHN DOE
Member Number: 9999999*99
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: 99999999999999999999
PCP Phone: 999-999-9999

Medicaid #: 999999999999
DOB: 99-99-9999

Detailed benefit information is available at optimahealth.com



Preauthorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

FOR PHARMACIST USE ONLY:

BIN# 610011 PROCESSOR CONTROL# OHPMCAID
OptumRx Pharmacist Help Desk: [1-866-244-9113]

Member Services: *(Translation Services Available)*	[757-999-9999] OR [9-999-999-9999]
Pharmacy Member Services:	[757-552-8877] OR [1-844-672-2307]
TTY Virginia Relay Service: *(Hearing Impaired)*	[711] OR [1-800-828-1140]
After Hours Nurse Advice:	[757-552-8899] OR [1-844-387-9420]
Smiles for Children:	[1-888-912-3456]
Transportation:	[1-877-892-3986]
Behavioral Health Pre Authorization:	[757-552-7174] OR [1-800-648-8420]
Provider Relations:	[757-552-7474] OR [1-800-229-8822]
Medical/Pharmacy Pre Authorization:	[757-552-7540] OR [1-800-229-5522]

MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

BEHAVIORAL HEALTH CLAIMS
P.O. Box 1440
Troy, MI 48099-1440

Offered by Optima Health Plan

UnitedHealthcare Community Plan:

UnitedHealthcare Community Plan

Health Plan (80840) 911-87726-04

Member ID: 999999999 Group Number: 99999

Member:
SUBSCRIBER M BROWN
Medicaid ID XXXXXXXXX
PCP Name:
PROVIDER BROWN
PCP Phone: (999) 999-9999

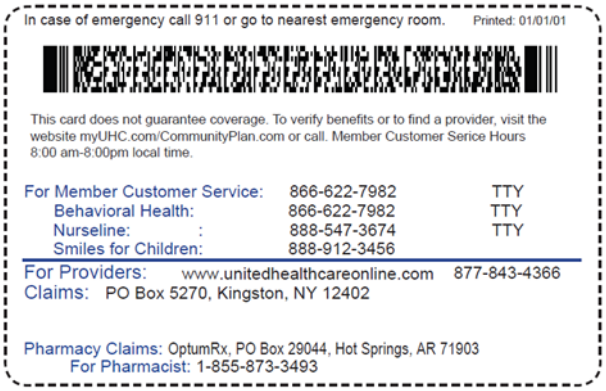
Payer ID: 87726

OPTUMRx

Rx Bin: 610494
Rx Grp: ACUVA
Rx PCN: 4444

UnitedHealthcare Community Plan
Administered by UnitedHealth Insurance Company

0000



In case of emergency call 911 or go to nearest emergency room. Printed: 01/01/01

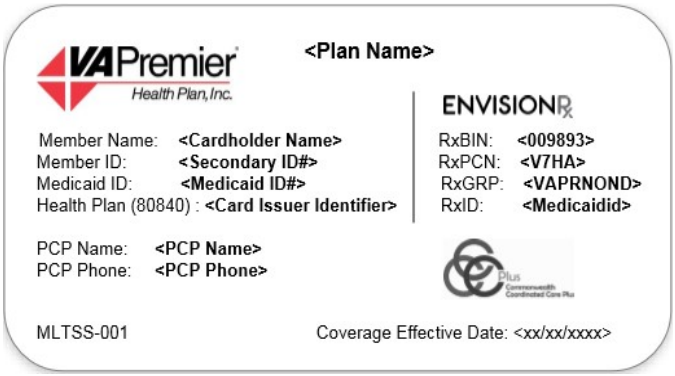
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myUHC.com/CommunityPlan.com or call. Member Customer Serice Hours 8:00 am-8:00pm local time.

For Member Customer Service:	866-622-7982	TTY
Behavioral Health:	866-622-7982	TTY
Nurseline:	888-547-3674	TTY
Smiles for Children:	888-912-3456	

For Providers: www.unitedhealthcareonline.com 877-843-4366
Claims: PO Box 5270, Kingston, NY 12402

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacist: 1-855-873-3493

Virginia Premier Health Plan:



VA Premier Health Plan, Inc.

<Plan Name>

Member Name: **<Cardholder Name>**
Member ID: **<Secondary ID#>**
Medicaid ID: **<Medicaid ID#>**
Health Plan (80840) : **<Card Issuer Identifier>**

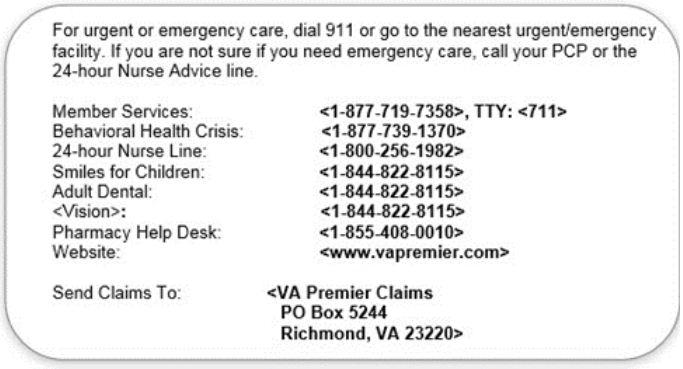
ENVISIONRx
RxBIN: **<009893>**
RxPCN: **<V7HA>**
RxGRP: **<VAPRNOND>**
RxID: **<Medicaidid>**

PCP Name: **<PCP Name>**
PCP Phone: **<PCP Phone>**

Plus Commonwealth Coordinated Care Plus

MLTSS-001

Coverage Effective Date: <xx/xx/xxxx>



For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you are not sure if you need emergency care, call your PCP or the 24-hour Nurse Advice line.

Member Services:	**<1-877-719-7358>, TTY: <711>**
Behavioral Health Crisis:	**<1-877-739-1370>**
24-hour Nurse Line:	**<1-800-256-1982>**
Smiles for Children:	**<1-844-822-8115>**
Adult Dental:	**<1-844-822-8115>**
<Vision>:	**<1-844-822-8115>**
Pharmacy Help Desk:	**<1-855-408-0010>**
Website:	**<www.vapremier.com>**

Send Claims To: **<VA Premier Claims**
PO Box 5244
Richmond, VA 23220>